South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5722

(For Commission Use Only:
ATTACH MAILING LABEL IDENTIFYING
INSURANCE CARRIER IN THIS AREA)

Minor Medical Claims for
Calendar Year _____

I. Carrier Identification

If missing or incorrect above

Insurance Carrier FEIN: _____ Insurance Carrier SCWCC Code No.: _____

Insurance Carrier Name: _____

II. Reporting Contact Address

☐ The address shown above is the correct contact for completion of this form.

OR

☐ Future editions of this form should be sent to the following address:

Address: _____

_____

City: _____ State: _____ Zip: _____

III. Statistical Report

This is the include ALL minor medical claims paid in the name of or under the authority of the named Carrier/Self-insurer during the calendar year.

Submitted by: _____ Telephone: ___ - ___ - _____
Preparer's Name

Total # minor medical claims filed during calendar year: _____

Total medical costs paid during calendar year: **$** _____

File this form with the Accident Reporting Division on or before April 1 following the reporting year. Only one report per carrier will be accepted.